Statement for the Record
by the
American Federation of State, County and Municipal Employees (AFSCME)
For the Hearing on
the President's and Other Bipartisan Proposals to Reform Medicare
Before the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
May 21, 2013

This statement is submitted on behalf of the 1.6 million workers and retiree members of the American Federation of State, County and Municipal Employees (AFSCME).

AFSCME is proud of labor's historic role in the creation Medicare, a federal social insurance program that is indispensable to our country. When President Johnson signed Medicare into law on July 30, 1965, he spoke of its profound promise:

> "No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents, and to their uncles, and their aunts. And no longer will this Nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this progressive country."

For today's 50 million Medicare beneficiaries and the millions who will depend on this program in the future, the need for Medicare to remain a bulwark against financial ruin caused by the caprice of illness and disability rings as true in 2013 as it did nearly five decades ago.

Changes to Medicare Should be Aimed at Improving Coverage, Not Deficit Reduction

Half of all people with Medicare live on incomes of less than $22,000 per year. Medicare households spend 15% of income on health care costs compared to the just 5% spent by non-Medicare households. In short, Medicare beneficiaries are often forced to choose between making ends meet and getting the medical care they need. Increasing out-of-pocket health care costs for beneficiaries will jeopardize the health of seniors and individuals with disabilities who rely on Medicare.

As Congress looks at beneficiary cost sharing within the Medicare program, the focus must be on expanding benefits and reducing beneficiary costs. Medicare benefit design must not be a diversion to disguise shifting costs onto beneficiaries or employers who provide retiree coverage or making health care unaffordable for the majority of seniors and individuals with disabilities. While the details may vary, the underlying premise of many proposals is to increase out-of-pocket costs

for beneficiaries, all of which is under the pretense that Medicare beneficiaries are over-insured and increased cost sharing is an appropriate means of limiting unnecessary health care services.

Increasing beneficiary cost sharing (either directly or by constraining supplemental policies that cover Medicare cost sharing) is a misguided approach to benefit redesign because it will limit beneficiary access to necessary care. Building in extra costs and charges for beneficiaries is a blunt and inefficient tool for cutting costs. In reducing utilization, it will prevent beneficiaries from getting the appropriate care they need. This troubling implication is acknowledged by the Medical Payment Advisory Commission (MedPAC) in its June 2012 benefit redesign proposal. The National Association of Insurance Commissioners (NAIC) has strongly recommended against further cost sharing to Medicare supplemental insurance policies, known as Medigap plans, because of the harm to the health of beneficiaries and the Medicare program in the long run.[1]

The classic RAND Health Insurance Experiment, which did not include Medicare beneficiaries, found the reduced use of services resulted primarily from participants deciding not to initiate care. But it reduced both needed and unneeded health care services. Once patients entered the health care system, cost sharing had a limited effect on intensity or cost of an episode of care. The study also found that the absence of cost sharing (free care) improved the control of treatable chronic diseases, such as hypertension, improving the mortality of patients, especially for the poorest patients in the experiment. The implication from this study is that cost sharing is an unreliable tool for reducing health care use and that reducing costs for treatable conditions can save lives.

It seems dubious at best (and potentially cruel at worst) to ask beneficiaries with multiple conditions and illnesses to second-guess their doctor's recommendations or to shoulder the full responsibility of evaluating the extent to which they need medical care in the first place. Increasing cost sharing does more harm than good for the very sick, for the old and for the poor. While asking beneficiaries to pay higher co-pays or coinsurance may reduce federal expenditures in the short run, it simply moves these costs from the government onto beneficiaries.

Increasing cost sharing focuses on the wrong problem as a means of curbing overall health care costs and is not likely to remedy high costs. As compared with other industrialized nations, our high medical spending is driven by high prices, not high utilization.[2] Raising the out-of-pocket costs on beneficiaries will not reduce high medical prices. Indeed, providers may increase prices if utilization drops.

Medicare is an amazing success story – providing health and financial security to millions of Americans even during the worst economic crisis since the Great Depression. AFSCME urges Congress to reject proposals to redesign Medicare in a way that builds in extra cost sharing for beneficiaries. This would allow sick and older seniors and individuals with disabilities, who are on limited incomes, to be denied the needed health care because of additional out-of-pocket costs.

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[1] National Association of Insurance Commissioners, "Medicare Supplemental First Dollar Coverage and Cost Shares Discussion Paper" (October 2011).

[2] Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan, "It's The Prices, Stupid: Why The United States Is So Different From Other Countries" Health Affairs, 22, no.3 (2003):89-105.

While we oppose achieving short-run federal savings through beneficiary cost savings because such savings are shortsighted, we do support eliminating sweetheart deals for the pharmaceutical industry that cost Medicare. For example, when Congress enacted the Medicare Part D drug benefit, it prohibited Medicare from negotiating lower drug prices with drug companies. Ending this prohibition could save Medicare more than $200 billion over ten years. In addition, the Medicare Part D law resulted in a substantial drug manufacturer windfall because it ended the then-existing requirement that manufacturers pay rebates for beneficiaries who are eligible for both Medicare and Medicaid (known as dual eligible) and low-income Part D enrollees. Reinstating the rebates that were required before 2006 would ensure that taxpayers and the Medicare program do not overpay for Part D drugs.

We would be remiss if we did not point out that Medicare excludes the vital services that many seniors and individuals with disabilities need to maintain their independence – such as long-term supports and services. Medicare provides limited post-acute care and few Americans can afford private long-term care insurance. Medicaid is by default the provider of long-term care services, but requires seniors and individuals with disabilities to impoverish themselves to get the services they need to complete life's daily activities. As America ages, the gaps in coverage for long-term care will further strain and challenge families, communities and our country. We urge Congress to support efforts by the Commission on Long-term Care to address this urgent and growing need for long-term supports and services.

In sum, Medicare has helped generations of Americans keep a toehold in the middle class. As Congress considers the adequacy of Medicare's benefit design, we urge the Congress to reject proposals that seek to shift costs from the government onto beneficiaries. The goal of benefit redesign should be to ensure that benefits are adequate, not to achieve deficit reduction.